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## **MENTAL HEALTH POLICY PAPER**

# **Lessons learned in developing community mental health care in Africa**

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*This paper summarizes the findings for the African Region of the WPA Task Force on Steps, Obstacles and Mistakes to Avoid in the Implementation of Community Mental Health Care. We present an overview of mental health policies, plans and programmes in the African region; a summary of relevant research and studies; a critical appraisal of community mental health service components; a discussion of the key challenges, obstacles and lessons learned, and some recommendations for the development of community mental health services in the African region.*

**Key words:** Community mental health care, Africa, primary health care, mental health services, systematic review, lessons learned

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This paper is one of a series which describes the development of community mental health care in regions around the world. In 2008 the WPA General Assembly approved the Action Plan of the Association for the triennium of the Presidency of Professor Mario Maj (1,2), who commissioned a Task Force to produce a WPA Guidance on Steps, Obstacles and Mistakes to Avoid in the Implementation of Community Mental Health Care. The purpose, methods and main findings of this Task Force have recently been published (3). In this article, we describe these issues in relation to Africa.

The Africa region of the World Health Organization (WHO) includes 46 countries, 30 of which are classified as low-income. Mental disorders appear to be at least as prevalent as in high-income countries, with a lifetime prevalence estimated to be 30.3% (4). Mental health vies for its place amongst other compelling public health priorities and yet has demonstrated importance for achieving the Millennium Development Goals (5). However, funding for mental health care in the African region remains disproportionately low when compared to the associated burden of mental disorder (6). Further challenges to the development of mental health services in the Africa region come from the impact of conflicts, natural disasters and the brain drain of mental health professionals from government services (7).

In this paper, we review the implementation of community mental health care across African countries, with particular emphasis given to published evaluations of services and the experience of experts within the region.

### **MENTAL HEALTH POLICIES, PLANS AND PROGRAMMES IN THE AFRICA REGION**

At the time of the publication of the WHO Mental Health Atlas (8), there were only 23 countries with a mental health policy in the Africa region, with a further six countries in the process of developing a policy. Nine countries had a mental health programme in the absence of a policy. Twenty five

countries had mental health legislation, although the majority had not been revised recently. Only 56.5% of African countries reported having community-based mental health care.

Even though many policies support the decentralization of mental health services and development of community-oriented services, actual implementation has been a great challenge across the African continent (9-11). For most low-income African countries, achieving adequate population coverage with any kind of mental health care provision has been problematic, resulting in high treatment gaps for even the most severe mental disorders (6).

### **SUMMARY OF RELEVANT RESEARCH WITHIN THE AFRICA REGION**

A systematic review of published and grey literature was undertaken in order to identify studies evaluating the implementation of community mental health care in Africa. The methodology has been described (3). In this paper, only studies conducted between 1995 and 2009 are considered, as older studies have been reviewed previously (12).

A total of 24 evaluations of community mental health services were identified. Their findings have been synthesized and presented in Tables 1-3. Reviews of evidence and experience arising from implementation of community mental health care were also identified, both from South Africa (34,35).

The vast majority of published mental health service research in sub-Saharan Africa has been carried out in South Africa (n=17; 70.8%), an upper-middle income country. There is a conspicuous lack of published literature evaluating the implementation of community mental health care in low-income sub-Saharan Africa countries. Only a minority of studies (n=5; 20.8%) included a comparative element to their evaluation, either comparing pre- to post-intervention, or referring to another service model, and none employed randomization.

The identified studies have considered different models of





**Table 1** Synthesis of studies evaluating quality of mental health care in primary care settings in sub-Saharan Africa

Evaluated component	Findings
Diagnosis	Diagnostic sensitivity 76%, specificity 98% (Guinea-Bissau) (13); diagnosis not recorded in 44% of cases (S. Africa) (14); low awareness of non-psychotic mental illness (S. Africa) (15)
Psychiatric history	Judged adequate in 89% of cases (S. Africa) (16)
Medication	Inappropriate prescription in 8% of cases for emergency medication, in 40% for long-term medication (S. Africa) (16); polypharmacy in 88% of cases (S. Africa) (14); only 10% of nurses confident to make changes (S. Africa) (14); erratic medication supply in Ghana, Kenya, Tanzania, Uganda (18)
Psychosocial therapies	After brief training in rehabilitation, fidelity to model maintained after 18 months (S. Africa) (19); limited availability of therapies in routine practice (15,20)
Continuity of care	15-18% lost to follow-up (S. Africa) (17); 36% not seen in six months (S. Africa) (14)
Staffing	High turnover (S. Africa, Guinea-Bissau, Tanzania) (13,15,18)
Supervision	Lined to specialist service found to be essential (Guinea-Bissau) (13)

**Table 2** Synthesis of studies evaluating professionals' and users'/carers' views on mental health care in primary care settings in sub-Saharan Africa

Evaluated component	Findings
<i>Primary health care workers' views</i>	
Training in mental health care	Inadequate (15,21,22)
Attitudes towards new role	Increased stress in 50% of respondents (S. Africa) (21); 84% said specialists should retain responsibility (S. Africa) (21); back-up highly appreciated (S. Africa) (23); residual negative attitudes towards new role (S. Africa) (23)
Implementation	62% felt services were understaffed (S. Africa) (23); no transport/time for outreach (S. Africa) (23); 79% felt services were restricted to prescribing medication (S. Africa) (21); understand need for psychosocial care but in practice constrained (S. Africa) (24); limited social services (S. Africa) (23)
<i>Patients' views</i>	
Satisfaction with care	Majority (>90%) satisfied but >50% of black patients preferred long-stay hospital care (S. Africa) (25); good accessibility, less stigmatizing when integrated into general care (S. Africa) (23); generally high satisfaction with care (Uganda) (23); lack of attention to physical health if separate mental health clinic but longer waits, less continuity, poorer quality if integrated into general care (S. Africa) (23)
Symptoms	Reduction following intervention reported by patients/carers (Guinea-Bissau) (13)
Functioning	Vocational/occupational functioning improved after rehabilitation (S. Africa) (19)
<i>Carers' views</i>	
Attitudes towards providing care	Majority happy but high proportion preferred day/long-stay hospital care (S. Africa) (25)
Satisfaction with provided care	High overall satisfaction (S. Africa) (22); lack of continuity and long waiting times (S. Africa) (22); need for more support (26)

community-based mental health care, ranging from specialist assertive outreach teams to variations on the integration of mental health into primary health care, for example: joint clinics between primary care workers and mental health nurses, mental health nurses working in a primary care setting, and primary care workers providing the bulk of mental health care with varying degrees of specialist mental health support. Little is known about the relative merits of these different approaches, as direct comparisons of effectiveness are rare (23).

Much of the focus of studies has been on the quality of mental health care provided within primary care, and the skills, knowledge and attitudes of primary care workers in regard to the diagnosis and management of mental disorders. Previously, studies of the effectiveness of training primary care workers to deliver mental health care have been criticized for relying on self-reports from these workers (subject to social desirability bias) and failing to look at the sustainability of the

effect of training (12). By examining case records kept by primary care workers (17), some of the subjectivity of assessment can be overcome, although documented practice may not fully accord with actual clinical practice. Some studies incorporating observational methods have yielded important insights (20,24), for example, revealing that the emotional work of dealing with patients with mental disorders may contribute to primary care workers operating in a task-oriented biomedical model of care rather than the more holistic model envisaged by the primary care model (24).

Although several studies included evaluations of the levels of satisfaction with services expressed by patients and their families (e.g., 22), and one study considered patient's social outcomes (17), we did not identify any study that evaluated patients' clinical outcomes using standardized diagnostic or symptom scales, and no study looked at patient experience of side effects of medication or physical health parameters.





**Table 3** Synthesis of studies evaluating specialist community mental health services and service interfaces

Evaluated component	Findings
<i>Specialist community mental health services</i>	
Prescription of medications	Unnecessary polypharmacy in 9% of cases (S. Africa) (28); prescription inappropriate for diagnosis in 12-17% of cases (S. Africa) (28)
Psychosocial interventions	Minimal resources available (S. Africa) (15,20)
Referral for frequent relapses	Rarely occurred (S. Africa) (28)
Follow-up	43-46% lost to follow-up (S. Africa) (28); follow-up mostly clinic-based (Botswana) (26)
Service provided	Narrow focus on prescribing by psychiatric nurses (S. Africa) (29); largely biomedical approach by psychiatric nurses (Botswana) (26); minimal resources available for prevention, promotion, training (S. Africa) (15); only 8-10 minutes available for assessment/review (S. Africa) (29)
Staffing	District mental health practitioners diverted to general health care (S. Africa) (15)
<i>Service interfaces</i>	
Sustainability	Difficulty sustaining (e.g., Ghana) (18)
Cost-benefit of service	Demonstrated benefits in Guinea-Bissau (13)
Referral from community	Lack of cooperation from primary care workers; ambiguous role of community workers (S. Africa) (30); community volunteers not sustainable if unpaid (Uganda) (18); community awareness campaigns successful in increasing presentation (Nigeria, Uganda) (23,31)
Referrals upwards	Increased referral to regional not national services (Uganda) (23)
Outreach	Assertive outreach post-admission reduced readmission duration in revolving door patients (33); involvement of service users was successful in decreasing defaulting rates (Uganda) (18)

Only a handful of studies have attempted to evaluate the individual service processes necessary for successful implementation of community mental health care, for example, considering the effectiveness of referral networks (10,30). No studies were identified examining the quality and quantity of supervision required to enable adequate delivery of mental health care by primary care workers, despite the recognized importance of supervision for the success of integration of mental health into primary care (12). The finding that even mental health nurses seem reluctant to revise diagnoses, change medication protocols and proactively discharge patients from follow-up (27) underlines the importance of evaluating supervision arrangements.

There is also an absence of studies evaluating the effectiveness of psychosocial interventions delivered within the constraints of the primary care setting. One exception was the non-randomized study evaluating the incorporation of psychosocial rehabilitation for those with severe mental illness into the role of primary care nurses (19). Understanding whether similar brief interventions are feasible or effective in the primary care setting, or whether primary care workers can collaborate with non-governmental organizations (NGOs) and community-based organizations to provide such interventions is an important topic for future research.

### CRITICAL APPRAISAL OF COMMUNITY MENTAL HEALTH SERVICE COMPONENTS

There was evidence of diverse interpretations of the meaning of community care across countries. In the low-income countries of the Africa region, community mental health care

is largely restricted to mental health care delivered by primary care workers, with specialist mental health workers (usually psychiatrists and psychiatric nurses) tending to provide care through hospital-based outpatient clinics. Despite recommendations by WHO and others (23), there are only a few examples of specialist mental health workers being utilized to support mental health care in the primary care setting, through coordination and planning of local mental health care, supervision, in-service training, consultation for complex cases, and prevention and promotion activities.

Although more holistic care is an expected benefit of community mental health services, especially when integrated into primary care, studies have not necessarily shown this to be the case (27,29). Time pressures, a strongly biomedical model of care and limited resources to support non-medication interventions may mean that mental health care is reduced to the dispensing and administration of medication (24).

Without community sensitization and engagement, the detection of untreated patients and take-up of mental health care is unlikely to proceed successfully. Similarly, without strategies in place to deal with patients who default from care, mental health care in primary care may not be sufficiently flexible to respond to the particular needs of patients with mental health difficulties. As more specialist mental health workers tend to be located at regional and district levels of the health system in most African countries, they are limited in their abilities to provide responsive outreach services close to home. A number of countries have made use of trained community-based volunteers to overcome this problem (18,30), but the difficulty of maintaining motivation and sustaining the system when workers are not remunerated has been highlighted (34). Involvement of service user





groups to help support community outreach services has been applied successfully (18).

The potential role of traditional healers and religious leaders in the delivery of community-based care has been much discussed (36,37), but with few examples of this happening in practice. One example of traditional healers providing counselling services in conjunction with a community-based mental health service has been reported, although with no evaluation of patient outcomes (18).

The potential contribution of support groups, composed of service users and caregivers, to improving clinical outcomes and social inclusion, as well as lobbying for improved services, has been described but not formally evaluated (38,39).

Our systematic review of the literature was complemented by a survey of regional experts on their experiences of implementing community mental health care (3). Tables 4 and 5 summarize the challenges and lessons learned.

## RECOMMENDATIONS FOR THE AFRICA REGION

The new impetus given to scaling up of mental health services across low- and middle-income countries (40,41) has yet to manifest in terms of published evaluation studies establishing the effectiveness of such services in Africa. None-

theless, an opportunity exists to build on the decades of experience, originally initiated by the WHO (42), and the existing evidence base in order to successfully implement models of community mental health care across Africa. Once stakeholders are engaged and political will is present, clear messages emerging from the evidence and experience to date support the importance of:

- Strengthening specialist mental health services at the same time as integrating mental health into primary health care.
- Increasing quality and sustainability of mental health in primary care through adequate supervision, ongoing on-the-job training and reliable referral networks.
- Developing robust mechanisms to ensure reliable supplies of psychotropic medications.
- Supporting the provision of simple and feasible psychosocial interventions to augment medication approaches in the time-pressed primary care setting.
- Evaluative research that considers:
  - a. How the interface between primary and secondary health services affects delivery of mental health care.
  - b. The clinical and social outcomes of individual patients, evaluated in a standardized and systematic way.
  - c. Innovative service models, including collaboration with traditional healers and religious leaders.
  - d. The relative cost-effectiveness of differing models of community care.

**Table 4** Challenges in implementing community mental health care in Africa

- Competing priorities
- Waning community engagement
- Reliance on community volunteers not sustainable
- Under-funding
- Paucity of mental health professionals
- Negative attitudes to mental health
- Concern about skills of staff and quality of care
- Difficulty sustaining in-service training
- Erratic supplies of psychotropic medication
- Lack of multi-sectoral collaboration, including traditional healers
- Escalating need and demand for services

**Table 5** Lessons learned implementing community mental health care in Africa

- It can be done
- Need for patience, perseverance and determination
- Sustainability requires making best use of existing systems
- Government commitment, existence of a mental health policy and legislation are crucial
- International support can greatly help
- Need to invest time to identify and cultivate allies for support
- Ensure collaboration between the key stakeholders
- Advocacy and community groups can influence policy makers
- A mental health coordinator at the local level is necessary
- Supervision of primary care workers is critical
- Importance of proper planning
- Need to integrate evaluation and monitoring
- Marginalization of mental health can block progress

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